

**STATE OF MICHIGAN**  
**DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

File No. 104490-001

v

Aetna Life Insurance Company  
Respondent

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Issued and entered  
this 15<sup>th</sup> day of June 2009  
by Ken Ross  
Commissioner

**ORDER**

**I**  
**PROCEDURAL BACKGROUND**

On April 23, 2009, XXXXX, on behalf of her infant daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* The Petitioner has group health care coverage underwritten by Aetna Life Insurance Company (Aetna).

Aetna was notified of the external review request and was asked to submit the information used in making its adverse determination. Aetna provided the information and documents to this agency on April 24, 2009. Petitioner's request for review was accepted on April 30, 2009.

The issue here can be decided by applying the terms of the Petitioner's Aetna policy. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

**II**  
**FACTUAL BACKGROUND**

In November 2008, Petitioner's family was on vacation in Florida when Petitioner, who was

two months old at the time, became ill. She was seen by a local pediatrician who advised Petitioner's parents to take her to a hospital emergency room. Petitioner was treated at the emergency room of XXXXX in XXXXX. Petitioner was diagnosed with pneumonia and was hospitalized for two days.

The hospital is in Aetna's provider network but the emergency room physician is part of a practice group that is not an Aetna network member. Aetna paid for the hospital charges and a portion of the physician's \$1,745.00 charge. Petitioner's parents are now being billed by the physician practice group for the portion of its fees that Aetna declined to cover. The amount at issue is \$1,548.29.

The Petitioner appealed through Aetna's internal grievance process. Aetna reviewed the claims but affirmed its decision. A final adverse determination was issued on April 10, 2009.

### **III ISSUE**

Is Aetna required to pay more for the emergency room physician's charges?

### **IV ANALYSIS**

#### Petitioner's Argument

The Petitioner's parents say that when they arrived at the emergency room they were told that their daughter's care was covered after their emergency room copayment of \$75.00. They say that no one informed them that the pediatric emergency care was provided by a non-network provider. They say that they had never heard of a situation in which a network hospital might have non-network staff. They believe the true situation with regard to their coverage was misrepresented to them.

#### Respondent's Argument

In its final adverse determination, Aetna states that they paid some benefits for the charge in question. Payment was the same as the amount of coverage Aetna provides to their in-network

providers. According to Aetna, “[W]hen services are rendered at a Preferred Care facility on an emergency basis, related charges by Non-Preferred Care providers affiliated with the facility are reimbursed at the Preferred Care benefit level subject to the reasonable charges determined by Aetna.”

Petitioner’s policy includes the definition of “reasonable charge”:

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider’s usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

Aetna asserts that their claim handling was consistent with the certificate of coverage.

#### Commissioner’s Review

The Commissioner understands the Petitioner’s parents’ unhappiness that they have incurred higher out-of-pocket costs than anticipated. However, in this external review the Commissioner is bound by the terms and conditions of the Petitioner’s policy. In this case, the policy provides that Aetna will pay in-network rates to non-network providers for emergency treatment. However, the non-network provider, not having a contract with Aetna, is not required to accept Aetna’s payment as payment in full. The non-network provider may bill an individual for the difference between the provider’s charge and Aetna’s reasonable and customary fee.

It is regrettable that the Petitioner apparently received incorrect information from the XXXXX staff. However, the Commissioner has no regulatory authority over hospitals and cannot require the hospital or other provider to accept Aetna’s payment as full payment for the care provided. Under the PRIRA, the Commissioner may only determine whether a claim was processed in a manner consistent with state insurance laws and the terms of the applicable policy or certificate of coverage. The Commissioner finds that Aetna did pay the Petitioner’s claim according to the terms

and conditions of Petitioner's policy.

**V**  
**ORDER**

The Commissioner upholds Aetna's adverse determination of April 10, 2009. Aetna is not required to pay any additional amount for the treatment provided by the emergency room physician.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.